FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023093

Facility Name: BALLARD NURSING CENTER, INC.

Address: 9300 Ballard Road (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847) 294-2300 **Fax #** (847) 827-0981

IDPA ID Number: 36-2897326

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Leland J. Cohn	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,546	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,546	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,093	9,594	10,803	35,490	8
9	SNF/PED					9
10	ICF	11,424	5,180	1,341	17,945	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,517	14,774	12,144	53,435	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.20%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 3,604

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	260,289	5,511	16,434	282,234		282,234		282,234			1
2	Food Purchase		230,672		230,672		230,672	(2,792)	227,880			2
3	Housekeeping	167,098	32,724		199,822		199,822		199,822			3
4	Laundry	105,249	20,023		125,272		125,272		125,272			4
5	Heat and Other Utilities			161,596	161,596		161,596		161,596			5
6	Maintenance	81,695		94,707	176,402		176,402		176,402			6
7	Other (specify):*											7
8	**TOTAL General Services**	614,331	288,930	272,737	1,175,998		1,175,998	(2,792)	1,173,206			8
	B. Health Care and Programs											
9	Medical Director			90,100	90,100		90,100		90,100			9
10	Nursing and Medical Records	2,440,046	100,688	192,208	2,732,942		2,732,942	(1,500)	2,731,442			10
10a	Therapy											10a
11	Activities	131,231	8,610	597	140,438		140,438		140,438			11
12	Social Services	83,686		3,024	86,710		86,710		86,710			12
13	Nurse Aide Training											13
14	Program Transportation			2,976	2,976		2,976		2,976			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,654,963	109,298	288,905	3,053,166		3,053,166	(1,500)	3,051,666			16
	C. General Administration											
17	Administrative	160,618		320,000	480,618		480,618	(70,000)	410,618			17
18	Directors Fees											18
19	Professional Services			156,149	156,149	(18,960)	137,189	(996)	136,193			19
20	Dues, Fees, Subscriptions & Promotions			50,086	50,086		50,086	(16,211)	33,875			20
21	Clerical & General Office Expenses	280,102	47,146	78,256	405,504		405,504	(6,345)	399,159			21
22	Employee Benefits & Payroll Taxes			560,578	560,578		560,578	(1,287)	559,291			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,082	4,082		4,082	(1,684)	2,398			24
25	Other Admin. Staff Transportation			8,348	8,348		8,348	(5,878)	2,470			25
26	Insurance-Prop.Liab.Malpractice			73,131	73,131		73,131	84,104	157,235			26
27	Other (specify):*							13,709	13,709			27
28	**TOTAL General Administration**	440,720	47,146	1,250,630	1,738,496	(18,960)	1,719,536	(4,588)	1,714,948			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,710,014	445,374	1,812,272	5,967,660	(18,960)	5,948,700	(8,880)	5,939,820			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BALLARD NURSING CENTER, INC.
0023093
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	18,960	
19	PROFESSIONAL FEES		18,960

To reclass cost of appealing real estate taxes

Facility Name & ID Number BALLARD NURSING CENTER, INC. #0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,593	59,593		59,593	317,344	376,937			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,105	144,105		144,105	612,943	757,048			32
33	Real Estate Taxes			219,246	219,246	18,960	238,206	136,433	374,639			33
34	Rent-Facility & Grounds			1,021,000	1,021,000		1,021,000	(969,714)	51,286			34
35	Rent-Equipment & Vehicles			14,843	14,843		14,843	26,515	41,358			35
36	Other (specify):*							14,563	14,563			36
37	**TOTAL Ownership**			1,458,787	1,458,787	18,960	1,477,747	138,084	1,615,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	422,975	415,311	37,378	875,664		875,664		875,664			39
40	Barber and Beauty Shops	17,842	1,114		18,956		18,956		18,956			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,820	126,820		126,820		126,820			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	440,817	416,425	164,198	1,021,440		1,021,440		1,021,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,150,831	861,799	3,435,257	8,447,887		8,447,887	129,204	8,577,091			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,158)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,357	30		9
10	Interest and Other Investment Income	(16,148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(634)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(279)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,287)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,857)	21		24
25	Fund Raising, Advertising and Promotional	(8,618)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,541)	20		28
29	Other-Attach Schedule	(29,165)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,330)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	174,534		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 174,534		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 129,204		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BALLARD NURSING CENTER, INC.

ID# 0023093

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2				2
3	Misc Income	(258)	21	3
4	Public Relations	(640)	20	4
5	Legal Fees:			5
6	Kattin etc Prior year	(1,221)	19	6
7	S Berger Collection	(1,987)	19	7
8	Pick Mangement Group			8
9	Non allowable Accounting	(4,310)	19	9
10	Other Admin Auto & Travel (logs not maintained)	(8,348)	25	10
11	ICLTC (COPE)	(398)	20	11
12	Out of State seminars	(1,684)	24	12
13	Trust Fees	(1,043)	19	13
14	1999 Med bill	(1,500)	10	14
15	Write off old O/S checks	(4,918)	21	15
16	Collection agency	(2,858)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(29,165)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,792)											(2,792)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,792)											(2,792)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,500)											(1,500)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(1,500)											(1,500)	16
	C. General Administration													
17	Administrative		(70,000)										(70,000)	17
18	Directors Fees													18
19	Professional Services	(11,419)	5,423	5,000									(996)	19
20	Fees, Subscriptions & Promotions	(16,476)	50	215									(16,211)	20
21	Clerical & General Office Expenses	(7,033)	688										(6,345)	21
22	Employee Benefits & Payroll Taxes	(1,287)											(1,287)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,684)											(1,684)	24
25	Other Admin. Staff Transportation	(8,348)	2,470										(5,878)	25
26	Insurance-Prop.Liab.Malpractice		1,859	82,245									84,104	26
27	Other (specify):*		13,709										13,709	27
28	**TOTAL General Administration**	(46,247)	(45,801)	87,460									(4,588)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,539)	(45,801)	87,460									(8,880)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	21,357	1,256	294,731									317,344	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,148)	(5,544)	634,635									612,943	32
33	Real Estate Taxes			136,433									136,433	33
34	Rent-Facility & Grounds		27,286	(997,000)									(969,714)	34
35	Rent-Equipment & Vehicles		26,515										26,515	35
36	Other (specify):*			14,563									14,563	36
37	**TOTAL Ownership**	5,209	49,513	83,362									138,084	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,330)	3,712	170,822									129,204	45

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Eli Pick	32.50%	N/A		Ballard Partners	Des Plaines, Il	Bldg Ownership
Moshe Pick	35.00%			Pick Management Group		Mgmt Company
Hadassah Pick	20.00%					
Sarah Fitterman	10.00%					
Gloria Pruzan	2.50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 320,000	Pick Management Group		$	$ (320,000)	1
2	V	25	Auto Expense		Pick Management Group		2,470	2,470	2
3	V	30	Depreciation		Pick Management Group		1,256	1,256	3
4	V	26	Insurance		Pick Management Group		1,859	1,859	4
5	V	20	License & Fees		Pick Management Group		50	50	5
6	V	21	Office Expense		Pick Management Group		688	688	6
7	V	19	Payroll Proceesing Fees		Pick Management Group		1,113	1,113	7
8	V	19	Accounting		Pick Management Group		4,310	4,310	8
9	V	34	Rent		Pick Management Group		27,286	27,286	9
10	V	17	Administrative Salaries		Pick Management Group		250,000	250,000	10
11	V	27	Payroll Taxes		Pick Management Group		13,709	13,709	11
12	V	32	Interest Income		Pick Management Group		(5,544)	(5,544)	12
13	V	35	Auto Lease		Pick Management Group		26,515	26,515	13
14	Total			$ 320,000			$ 323,712	$ * 3,712	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent Expense	1,021,000	Ballard Partners		$	$ (1,021,000)	15
16	V	36	Amortization		Ballard Partners		14,563	14,563	16
17	V	30	Depreciation		Ballard Partners		294,731	294,731	17
18	V	26	Insurance		Ballard Partners		82,245	82,245	18
19	V	20	License		Ballard Partners		215	215	19
20	V	19	Legal		Ballard Partners		5,000	5,000	20
21	V	34	Rent Expense		Ballard Partners		24,000	24,000	21
22	V	33	RE Taxes	243,000	Ballard Partners		379,433	136,433	22
23	V	32	Interest Income		Ballard Partners		(53,966)	(53,966)	23
24	V	32	Interest Expense		Ballard Partners		688,601	688,601	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,264,000			$ 1,434,822	$ * 170,822	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Moshe Pick	Executive Director	Administrative	35.00	None	40	100.00	Alloc Pick Mgt	$ 125,000	17-7	1
2	Eli Pick	Executive Director	Administrative	32.50	None	40	100.00	Alloc Pick Mgmt	125,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 250,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
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City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Allfirst Mortgage		x	Mortgage	$44,927.00	05/91	$ 4,500,000	$ 9,507,599	08/01/34	10.5000	$ 688,601	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank		x	Working Capital				1,100,000			133,489	6
7	Capitalize Leases		x	Equipment				93,461			10,258	7
8	Insurance		x								358	8
9	TOTAL Facility Related				$44,927.00		$ 4,500,000	$ 10,701,060			$ 832,706	9
	B. Non-Facility Related*											
10	Supplemental Schedule							190,000				10
11	Ballard Nursing Home	x		Interest income							(16,148)	11
12	Ballard Partners	x		Interest income							(53,966)	12
13	Pick Management	X		Interest income							(5,544)	13
14	TOTAL Non-Facility Related						$	$ 190,000			$ (75,658)	14
15	TOTALS (line 9+line14)						$ 4,500,000	$ 10,891,060			$ 757,048	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Various shareholders	X					$	$ 190,000			$ 0	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 190,000			$	21

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	360,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	355,679	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,321)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	360,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	18,960	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	374,639	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	334,024	8
	1996	331,607	9
	1997	335,298	10
	1998	352,039	11
	1999	355,679	12

Estimated based on 1999 tax bill

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 770,000 B. General Construction Type: Exterior brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1991	1973	$ 2,851,196	$ 96,557	35	$ 90,514	$ (6,043)	$ 915,239	4
5				1994	995,072	25,515	35	25,515		169,037	5
6				1994	986,459	25,294	35	25,294		154,926	6
7				1995	101,526	2,603	35	2,603		14,425	7
8											8
	Improvement Type**										
9	Various			1980	2,955		20			2,947	9
10	Various			1981	11,619		20			11,558	10
11	Various			1982	17,413		20			17,408	11
12	Various			1984	3,536		20			3,536	12
13	Various			1985	8,040		20			8,040	13
14	Various			1986	18,668		20	983	983	14,252	14
15	Various			1987	42,109	722	20	1,413	691	38,280	15
16	Various			1988	15,834	351	20	373	22	13,711	16
17	Various			1990	4,990	158	20	250	92	2,688	17
18	Various			1991	155,172	6,725	20	8,760	2,035	82,950	18
19	Various			1992	54,689	1,274	20	2,734	1,460	23,041	19
20	Various			1993	1,571	50	20	77	27	597	20
21	HEATING COOLING SYS			1996	2,312	59	20	116	57	532	21
22	Interior Signs			1996	350	9	20	18	9	82	22
23	BUILDING IMPROVEMENT			1996	70,114	1,798	20	3,506	1,708	16,069	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				423,500	33,936		28,234	(5,702)	88,972	34
35	PAGE 12A TOTALS				612,740	16,763		30,883	14,120	58,652	35
36	TOTAL (lines 4 thru 35)				$ 6,379,865	$ 211,814		$ 221,273	$ 9,459	$ 1,636,942	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AIR SYSTEM BALANCE			1996	1,762	45	20	88	43	403	9
10	MAV MOTOR REPLACEMEN			1996	2,000	51	20	100	49	458	10
11	INTERIOR SIGNS			1996	663	17	20	33	16	151	11
12	DRAPES			1996	616	16	20	31	15	142	12
13	COMP STATION CABLE			1996	2,566	66	20	128	62	587	13
14	Heat and Cooling Sys			1997	2,999		20	150	150	500	14
15	SEWAGE PUMP			1997	2,498	64	20	125	61	458	15
16	Caulking			1998	5,845	150	20	292	142	633	16
17	Renovation Patios			1998	6,134	157	20	307	150	768	17
18	A/C Rpairs			1998	2,124	54	20	106	52	274	18
19	Parking Lot			1998		51	20		(51)		19
20	ALARM SYSTEM			1998	2,500	64	20	125	61	365	20
21	SEWAGE PUMP			1998	2,498	64	20	125	61	375	21
22	A/C Couplings			1998	2,905	74	20	145	71	387	22
23	Patio Door			1998	2,040	52	20	102	50	247	23
24	MOTOR			1998	1,544	40	20	77	37	218	24
25	Sprinkler System			1998	3,500	90	20	175	85	423	25
26	Faucets,Couplings			1998	10,159	260	20	508	248	1,270	26
27	Compressor			1998	13,886	356	20	694	338	1,619	27
28	Medical Gas Piping			1999	124,600	3,195	20	6,230	3,035	10,903	28
29	Electrical Work			1999	201,699	5,172	20	10,085	4,913	19,330	29
30	Chiller Replacement			1999	76,355	1,958	20	3,818	1,860	6,363	30
31	AIR CARRIER			1999	693	18	20	35	17	38	31
32	Carpeting			1999	4,921	1,205	20	492	(713)	943	32
33	Loading Ramp & Patio			1999	127,175	3,261	20	6,359	3,098	11,128	33
34	Sprinkler Repairs			1999	2,850	73	20	143	70	191	34
35	Heating and Cooling			1999	8,208	210	20	410	200	478	35
36	TOTAL (lines 4 thru 35)				$ 612,740	$ 16,763		$ 30,883	$ 14,120	$ 58,652	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Flow Device Oxygen			1999	1,760	45	20	88	43	147	9
10	Emerg. Gener. Design			1999	11,614	291	20	568	277	1,136	10
11	DOOR CENSORS			1999	718	18	20	36	18	51	11
12	Signs			1999	18,235	468	20	912	444	1,520	12
13	METAL ENCLOSURE			1999	934	24	20	47	23	47	13
14	Parking & Aisle Pave			1999	65,443	1,627	20	3,272	1,645	5,255	14
15	Nurse call system			1999	49,222	1,262	20	2,461	1,199	3,897	15
16	Load Ramp - Design			1999	14,368	368	20	718	350	1,257	16
17	DOOR LOCKS			1999	2,781	71	20	139	68	185	17
18	FIRE PANEL			1999	978	25	20	49	24	78	18
19	Nurse Call System			2000	49,221	1,104	20	2,256	1,152	2,256	19
20	KEYLESS ENTRY SYSTEM			2000	1,250	28	20	58	30	58	20
21	Electrical Outlets			2000	7,600	122	20	253	131	253	21
22	VENTILATION BOILER			2000	5,696	79	20	166	87	166	22
23	Weil Mclain Boiler			2000	50,425	54	20	210	156	210	23
24	Hot Water boiler			2000	9,172	69	20	153	84	153	24
25											25
26	Telephone system			1999	83,381	26,682	20	16,676	(10,006)	22,235	26
27	Telephone system enhancement			2000	1,716	343	10	172	(171)	172	27
28											28
29	Pick Mgmt Group			1996	48,986	1,256	20		(1,256)	49,896	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 423,500	$ 33,936		$ 28,234	$ (5,702)	$ 88,972	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,310,353	$ 100,451	$ 135,447	$ 34,996		$ 779,539	37
38	Current Year Purchases	217,191	43,315	18,918	(24,397)		18,918	38
39	Fully Depreciated Assets	912,965		1,299	1,299		912,965	39
40								40
41	TOTALS	$ 2,440,509	$ 143,766	$ 155,664	$ 11,898		$ 1,711,422	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,820,374	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 355,580	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 376,937	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 21,357	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,348,364	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BALLARD NURSING CENTER, INC.
0023093
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Ballard Partners	1,114,857	70,278	112,204	41,926	638,263
Ballard Nursing Center	195,496	30,173	23,243	(6,930)	141,276
TOTALS	1,310,353	100,451	135,447	34,996	779,539
LINE 29: CURRENT YEAR					
Ballard Partners	204,594	40,920	18,320	(22,600)	18,320
Ballard Nursing Center	12,597	2,395	598	(1,797)	598
TOTALS	217,191	43,315	18,918	(24,397)	18,918
LINE 30: FULLY DEPRECIATED					
Ballard Partners	912,965		1,299	1,299	912,965
Ballard Nursing Center					
TOTALS	912,965		1,299	1,299	912,965
TOTALS (Should Tie to Totals on Page 13)					
Ballard Partners	2,232,416	111,198	131,823	20,625	1,569,548
Ballard Nursing Center	208,093	32,568	23,841	(8,727)	141,874
TOTALS	2,440,509	143,766	155,664	11,898	1,711,422

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Allocation from BallardPartners			$ 24,000			3
4	Additions	Allocation from Pick Management Group			27,286			4
5								5
6								6
7	TOTAL				$ 51,286 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,843 Description: Schedule attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Pick Management		$	$ 26,515	17
18					18
19					19
20					20
21	TOTAL		$	$ 26,515	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Ballard Nursing Center
Page14 -Equipment #0023093
########

Copier Rental	12,421
Storage Rental	2,327
Water	95
	14,843

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1;39-2;39-3	hrs	$ 90,653		$ 2,134	$ 1,056		$ 93,843	1
2	Licensed Speech and Language Development Therapist	39-1;39-2;39-3	hrs	16,413		2,616	4,308		23,337	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1;39-2;39-3	hrs	145,689		350	2,989		149,028	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				129,387		129,387	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-1;39-2;39-3		170,220		32,278	277,571		480,069	13
14	TOTAL			$ 422,975		$ 37,378	$ 415,311		$ 875,664	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	44,064
5	Lab & X ray	13,999
6	PEN Feeding	47,564
7	Oxygen	33,424
8	Other Supplies	27,444
9	Respiratory Therapy Supplies	103,475
10	Concentrtor	7,601
		277,571

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	32,278
2		
3		
4		
5		
6		
7		
8		
9		
10		
		32,278

	Other Therapies Staff (Column 3)	
1	Respiratory Therapy	170,220
		170,220

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 30,253	$ 30,667	1
2	Cash-Patient Deposits	30,457	30,457	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,216,112	2,216,112	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	163,198	194,843	6
7	Other Prepaid Expenses		816,377	7
8	Accounts Receivable (owners or related parties)	200,000	372,200	8
9	Other(specify): See supplemental schedule	316,451	397,430	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,956,471	$ 4,058,086	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		5,124,612	14
15	Leasehold Improvements, at Historical Cos		1,246,052	15
16	Equipment, at Historical Cost	297,938	2,527,732	16
17	Accumulated Depreciation (book methods)	(206,284)	(3,621,703)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		1,184,283	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 91,654	$ 6,460,976	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,048,125	$ 10,519,062	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 939,531	$ 942,934	26
27	Officer's Accounts Payable		500	27
28	Accounts Payable-Patient Deposits	20,532	20,532	28
29	Short-Term Notes Payable	1,193,461	1,193,461	29
30	Accrued Salaries Payable	364,798	364,798	30
31	Accrued Taxes Payable (excluding real estate taxes)	53,907	53,907	31
32	Accrued Real Estate Taxes(Sch.IX-B)		360,000	32
33	Accrued Interest Payable	13,305	70,509	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,585,534	$ 3,006,641	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	190,000	190,000	39
40	Mortgage Payable		9,507,599	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	563,904	563,904	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 753,904	$ 10,261,503	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,339,438	$ 13,268,144	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (291,313)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,048,125	$ #REF!	48

*(See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER, INC. **#** 0023093 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		
Interest Receivable	32,000	112,979
Due Related Entities	284,451	284,451
	316,451	397,430

OTHER NON CURRENT ASSETS:		
Construction In Progress		16,400
Utility Deposit		
Loan Costs		446,882
Due Related Entities		721,001
		1,184,283

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax -		
Non Care Property		

OTHER NON CURRENT LIABILITIES:		
Due Related Entities	563,904	563,904
	563,904	563,904

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (473,664)	1
2	Restatements (describe):		2
3	**Schedule attached**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (473,661)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(67,652)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (67,652)	17
	B. Transfers (Itemize):		
18	**Paid in Surplus**	250,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 250,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (291,313)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	BALLARD NURSING CENTER, INC. #	0023093	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(473,661)
Adjustments:		
		-
		-
		-
Round off adj		(3)
Total adjustments		(3)
Balance - Beginning of Year		(473,664)
Equity(Deficit) from Page 17 Col 1		(291,313)
Related Party		
Equity(Deficit)	-2457769	
Income	0	
		(2,457,769)
Combined Equity - End of Year		(2,749,082)

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,874,707	1
2	Discounts and Allowances for all Levels	(4,305,984)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,568,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,414,998	6
7	Oxygen	220,361	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,635,359	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,049	13
14	Non-Patient Meals	2,158	14
15	Telephone, Television and Radio	10,386	15
16	Rental of Facility Space		16
17	Sale of Drugs	761,258	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	79,821	20
21	Other Medical Services	262,487	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 1,139,159	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,148	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,148	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	20,846	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,846	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,380,235	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,175,998	31
32	Health Care	3,053,166	32
33	General Administration	1,738,496	33
	B. Capital Expense		
34	Ownership	1,458,787	34
	C. Ancillary Expense		
35	Special Cost Centers	894,620	35
36	Provider Participation Fee	126,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,447,887	40
41	**Income before Income Taxes (line 30 minus line 40)****	(67,652)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (67,652)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BALLARD NURSING CENTER, IN # 0023093 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION		AMOUNT
1	Vending Commissions		1,122
2	Gain on Sale of Equipment		6,277
3	Misc. Income	(Adjusted out on Page 5A)	258
4	Fines & Penalties		3,188
5	Prior Period Adjustments	(Adjusted out on Page 5A)	4,918
6	Real Estate Tax Refund	(93 and 94) Not used to calculate rates	4,771
7	State Income Tax Refund		312
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	TOTALS		20,846

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 62,447	$ 30.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,467	35,420	760,300	21.47	3
4	Licensed Practical Nurses	19,293	20,867	383,335	18.37	4
5	Nurse Aides & Orderlies	92,359	98,611	1,220,798	12.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	20,180	21,691	422,975	19.50	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,925	2,091	27,062	12.94	9
10	Activity Assistants	10,826	11,718	104,170	8.89	10
11	Social Service Workers	5,817	6,325	83,686	13.23	11
12	Dietician	1,956	2,169	38,990	17.98	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,258	19,802	161,276	8.14	15
16	Dishwashers	9,178	9,604	60,023	6.25	16
17	Maintenance Workers	4,646	5,350	81,695	15.27	17
18	Housekeepers	24,105	25,433	167,098	6.57	18
19	Laundry	12,332	13,189	105,249	7.98	19
20	Administrator	1,030	1,383	69,837	50.50	20
21	Assistant Administrator	1,832	1,910	90,781	47.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,011	17,111	280,102	16.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,301	1,488	13,167	8.85	31
32	Other Health Care(specify)					32
33	Other(specify)	1,834	2,007	17,842	8.89	33
34	TOTAL (lines 1 - 33)	276,350	298,249	$ 4,150,833 *	$ 13.92	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	457	$ 16,434	1-3	35
36	Medical Director	Monthly	90,100	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,543	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	597	11-3	44
45	Social Service Consultant	Quarterly	3,024	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	472	$ 123,730		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,441	$ 155,997	10-3	50
51	Licensed Practical Nurses	619	22,637	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	4,060	$ 178,634		53

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Barber & Beauty	1,834	2,007	$ 17,842	$ 8.89
	1,834	2,007	$ 17,842	$ 8.89

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Liborio Cavallero (01/01/00-8/11/00)	Administrator		$ 69,837
Sue Mikalis	Asst. Admin		90,781
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,618

B. Administrative - Other

Description	Amount
Pick Mangement Group	$ 320,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 320,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR &R	Accounting	$ 43,300
HDSI	Data processing	9,758
Resource Systems	Data processing	765
Administar Fed	Data processing	240
Advance network Design	Data processing	4,368
Dart Chart Systems	Medicare consulting	20,460
Systematic Mgmt Sys	Medicare consulting	3,199
Rockwood Company	Trust fees	1,043
Brenda Cohen	AR consultant	28,063
Daniel F McGovern & Assoc	Real Estate Tax Cons.	18,960
Health Care Solutions	Collections	2,858
Schedule attached		23,136
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 156,150

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,061
Unemployment Compensation Insurance	42,203
FICA Taxes	308,218
Employee Health Insurance	164,281
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	2,528
TOTAL (agree to Schedule V, line 22, col.8)	$ 559,291

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,800
Advertising: Employee Recruitment	8,337
Health Care Worker Background Check	
(Indicate # of checks performed 243)	2,190
Licenses & fees	12,528
Dues & subscriptions	10,290
Advertising & Promo	11,941
Allocation from Pick	50
Allocation from Ballard Ptnrs	215
Political Contribution (COPE)	(398)
Less: Public Relations Expense	(640)
Non-allowable advertising	(8,897)
Yellow page advertising	(6,541)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,875

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,398
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,398

* Attach copy of IMRF notifications

**See instructions.

Ballard Nursing Center
Supporting Schedules #0023093
12/31/2000

Page 21-C Professional Fees (cont)

Jarosz Associates	Human Resources	(6,476.00)
Sue Weichert	Medicare consultant	8,834.00
Paula Kagan	HMO consultant	225.00
GatesMcdonald	UC Cons	1,650.00
Press, Ganey Assoc	Satisfaction survey	8,347.00
Caredata	Clinical Outcome	3,000.00
Richard Peelo & Assoc	Medicare consultant	4,300.00
OWP&P Consultants	Interior cons	428.00
Katten Muchin & Zavies	Legal	1,221.00
Sidney R Berger	Legal	1,987.00
Seyfarth Snaw & Fairweather	Legal	73.00
Gary Weintraub	Legal	(453.00)
		23,136.00

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALLARD NURSING CENTER, INC. # 0023093 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC 9055**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,605** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **126,819**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,158**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw